Patient Name: ______________________________ Date: ____________________

Were you referred by a medical provider? If yes, by whom? ______________________________

Primary Care Physician: ______________________________

For patients 12 years or older:

Tobacco use? (circle one)	Never Used	Former User	Current User

For patients 12-13 years old:

Has the patient had one dose of the meningococcal vaccine between the patient's 11th and 13th birthdays?	Yes	No
Has the patient had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) between the patient's 10th and 13th birthdays?	Yes	No
Has the patient completed the HPV vaccine series between the patient's 9th and 13th birthdays?	Yes	No
Did the patient not recieve any of the vaccinations above because of a medical reason, including allergic/anaphylaxis reaction or hospice services?	Yes	No

For patients 65 years or older:

Do you have an advanced directive?	Yes	No
Do you have a medical power of attorney?	Yes	No
If yes, is it currently in effect?	Yes	No
If yes, please list name of acting medical power of attorney:		

#83 MIPS 4.24

DETAILED VOICEMAILS

Would you like DMGNC's staff to leave a detailed voice message on your preferred phone number?

This may include information such as appointment details, prescription refill status, test/labs/procedure results, and/or insurance authorization information.

Yes________ No________ If yes, please confirm you preferred number: ____________________

Signature______________________________ Date____________________

DMG Form #19C